

Pediatric Pulmonology Year in Review 2015: Part 1

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ABSTRACT

Our journal covers a broad range of research and scholarly topics related to children's respiratory disorders. For updated perspectives on the rapidly expanding knowledge in our field, we will summarize the past year's publications in our major topic areas, as well as selected publications in these areas from the core clinical journal literature outside our own pages. The current review covers articles on neonatal lung disease, pulmonary physiology, and respiratory infection.

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Introduction

Our journal covers a broad range of research and scholarly topics related to children's respiratory disorders. For updated perspectives on the rapidly expanding knowledge in our field, we will summarize selected publications from the past year in our major topic areas, as well as selected publications in these areas from the core clinical journal literature outside our own pages. The current review covers articles on neonatal lung disease, pulmonary physiology, and respiratory infection.

Neonatal lung disease and bronchopulmonary dysplasia (BPD)

Bronchopulmonary Dysplasia (BPD) and its Etiology

Premature birth has implications for long term health even without well-known complications like BPD, a well-established exacerbating factor for adverse pulmonary and neurodevelopmental outcomes. This continues to motivate the search for preventive strategies based on improved mechanistic insights, as well as more accurate descriptions of long-term pulmonary health effects, among others.

Clinical studies have made it clear that BPD is multifactorial and that multiple gene families contribute to increased BPD risk. BPD and prematurity are important predisposing factors for later susceptibility to sequelae of respiratory insults such as COPD. The developmental window(s) of vulnerability and the threshold magnitude of oxidative stress have been explored in a variety of animal model systems. Maduekwe et al. tested the concept that accumulated hyperoxia exposure during neonatal and juvenile lung development (time x concentration) in mice would predict susceptibility to adult influenza-induced lung injury¹. While a minimum FiO₂ of 0.6 appeared to be required, it is not yet certain that early postnatal hyperoxia (postnatal days 4-8) is required for the phenotype of alveolar

enlargement and aberrant elastin deposition in adult mice. Knaapi et al.² report that overexpression of cathepsin K, a protease implicated in inflammatory lung conditions such as BPD, in transgenic mice has some limited protective effects during neonatal hyperoxia exposure. Limiting the damage from positive pressure ventilation has been widely proposed and embraced, with a trend towards using volume-targeted SIMV. Musk et al. treated surfactant deficient premature lambs with synchronized intermittent mandatory ventilation (SIMV) or high frequency jet ventilation (HFJV) using a volume targeted approach (7 mL/kg) for SIMV breaths in both treatment groups³. Although HFJV is designed to minimize airway pressure amplitude (ΔP) at the level of the alveoli, they reported no differences in gas exchange, pulmonary blood flow, or histologic evidence of lung injury between the two ventilation groups. The duration of the study was 180 minutes and the lambs were anesthetized with propofol and remifentanyl, so it may be that differences between ventilation approaches would have emerged with longer duration and less sedation that would be typical in clinical applications. As in the clinical trials of mechanical ventilation approaches in ARDS, using an open-lung approach⁴ while avoiding overdistension may be the key to minimizing lung injury attributable to mechanical ventilation.

Host susceptibility factors based on genotype have been shown to be relevant for experimental BPD. Huusko and colleagues⁵ report for the Gen-BPD Study group that Kit ligand gene polymorphisms in humans are significantly associated with risk for BPD and importantly that elevations of Kit ligand protein in umbilical cord blood also confer elevated BPD risk. Because of the role of the Kit pathway in mast cell maturation and proliferation, elevated cord blood Kit ligand may be identifying pro-inflammatory conditions *in utero*, which are known to increase BPD risk.

As noted in the 2014 Year in Review, center effect is a profound determinant of BPD risk⁶ and there are numerous attempts to better characterize those at greatest risk early in their courses of treatment in order to intervene at the right time. A variety of so-called BPD risk scores have been developed to partly address this need. A single center study reported by Malkar et al.⁷ confirmed earlier

reports that elevated respiratory severity at age 30 days, calculated as $\text{FiO}_2 \times \text{mean airway pressure}$, was predictive of mortality, which is unsurprising given that persistent need for mechanical ventilation at age 30 days would identify a very high risk group. As the authors pointed out, caution must be exercised when generalizing predictive scores obtained from a single center, particularly if the mortality or BPD risk in the center were skewed in some way.

Efforts to limit and optimize mechanical support have led to wider use of non-invasive positive pressure ventilation, albeit with limited high-quality data to guide its use. Li and colleagues⁸ report in a review and meta-analysis that NIPPV has not been shown to decrease the need for IPV, hastening to add that a sufficiently powered prospective study has yet to be conducted. A pilot study by Kugelman and colleagues⁹ takes a step in that direction by comparing the efficacy of nasal IPPV versus humidified high flow (1-5 LPM) nasal cannula (HFNC) to prevent intubation, and suggesting that HFNC may be as effective as IPPV. Two limitations of the study are worth noting. First, the proportion of eligible patients actually enrolled was relatively small (76/293). Second, the choice of the flows delivered via HFNC were not systematically chosen by specified criteria. When patients do require endotracheal intubation, predicting successful extubation should limit further injury by limiting the need to re-recruit, and earlier extubation may improve outcomes¹⁰. Robles-Rubio et al. report an improved computational approach to respiratory inductance plethysmography that predicts extubation readiness in preterm newborns undergoing mechanical ventilation, observing that diminished variability of respiratory effort predicts failure¹¹. It is unclear whether low variability represents immaturity of neural signaling, diaphragmatic responsiveness or some combination. The authors speculate that the combination of decreased air flow variability and increased rib cage movement variability may signal relatively ineffective respiratory behaviors.

Prematurity: Pulmonary Sequelae

2015 was a particularly fertile year for publication of late pulmonary outcomes of prematurity in *Pediatric Pulmonology*. Thunqvist et al.¹² report results from a longitudinal cohort of patients diagnosed at 36 weeks with moderate or severe BPD from a single center (N=55). Mechanics measured using the raised volume rapid thoracoabdominal compression (RVRTC) method showed similarly impaired volumes and compliance in both moderate and severe BPD at age 18 months relative to published age-matched standards. This is at odds with other studies that have shown greater impacts of disease severity on lung function, but the methodologic variations and validity of so-called normal standard values were discussed in detail by the authors. Ronkainen et al.¹³ used a similar approach comparing conventional spirometry and diffusion tests (DLCO) in 88 unsedated older children (10-11.5 yr) that were born before 32 weeks gestation with 88 similar age controls born at term. In line with the early childhood results, airflow limitations and diminished diffusion capacity were prevalent in preterm born children, and worse in those diagnosed with BPD compared with control subjects. These effects of prematurity on diffusion in older school age children differed from the results reported by Assaf et al.¹⁴ among sedated three year olds, which showed no effect of prematurity on DLCO. It must be noted that Assaf et al. studied healthy prematures only, at a gestational age of 31.7 weeks, meaning those unaffected by significant lung disease, thus a less vulnerable population.

Using spirometry, Gibson and colleagues measured pulmonary function in adults born as very low birth weight (VLBW) newborns in the late 1970's to early 1980's¹⁵. Airflow limitations were present in the VLBW group compared with those with birthweight ≥ 2.5 kg, with a more pronounced decrement in those diagnosed with BPD. FEV1 in VLBW adults were more predictive of adult FEV1 than was the case with normal BW adults. Jiang et al.¹⁶ and Nève et al.¹⁷ contributed to addressing the need for more normative data by assessing pulmonary function in normal school-age subjects in their respective populations. The long-term clinical implications of the apparent deficits in lung function among adult

survivors of premature birth, particularly those diagnosed with BPD, is not yet clear, but may be more severe than earlier appreciated, as reviewed by Ronkainen and colleagues¹³.

In a retrospective study, Cristea et al. reported clinical data on a cohort of infants with bronchopulmonary dysplasia (BPD) who were ventilator dependent; these investigators reported that this population had severe airway obstruction that remained unchanged over time¹⁸. These findings suggest that children with a history of severe BPD have substantial impairment in lung function that will likely persist into adulthood, placing them at increased risk for future chronic obstructive lung disease.

Lung Hypoplasia: Pulmonary Sequelae

Congenital diaphragmatic hernia represents a severe interruption of lung development in many cases. Although some may be asymptomatic, others may suffer fatal pulmonary hypoplasia. Survivors that required lengthy courses of mechanical ventilation may be at particularly high risk for abnormal long-term lung function. Healy and colleagues¹⁹ analyzed pulmonary function using RVRTC and whole body plethysmography in sedated CDH survivors during infancy (6 and 18 months) and found higher lung volumes and airway resistance in children with CDH complicated by pulmonary hypertension (PH). As the authors noted, this is consistent with prior reports of enlarged, simplified alveolar structure that accompanies disrupted pulmonary vascular development in CDH-associated PH. An important addition from this study is the observation of longitudinal evaluations, at least in a subset of subjects. In those for whom longitudinal data were obtained, the PH-associated elevations in lung volumes persisted over time. Similar findings were noted by Panitch and colleagues²⁰ who used similar methods. They reported that abnormalities persisted up to three years, with severity correlating with the magnitude of presumed hypoplasia (surrogates being the need for patch closure, duration of mechanical ventilation, need for ECMO). The 'catch up' potential for lung growth may be durably impaired in those with severe

hypoplasia, often accompanied by persistent PH, possibly reflecting a decreased repertoire of functional progenitor cells. The approach to ameliorating pulmonary hypoplasia in this disease has suffered from a dearth of mechanistic studies as outlined by a review of pre-clinical studies by Eastwood et al.²¹ The authors underscore the need for common outcome measures to enable proper comparisons among the therapeutic approaches.

Pulmonary physiology

Physiologic measurements play a critical role in the care and study of pediatric respiratory diseases. In order for physiologic data to be useful, proper acquisition is imperative and robust normal reference data must be available for comparison²². In a study of infants with cystic fibrosis, Anagnostopoulou et al.²³ reported that lung clearance index (LCI) values were falsely normal when obtained using multiple breath washout (MBW) measurements of sulfur hexafluoride (SF6) with commercial equipment. MBW calculates LCI by tracing the molar mass of SF6 as it falls from 100% to 2.5%. The algorithm in commercial software utilizes end-inspiratory molar mass to define the initial 100% step in gas concentration. The investigators developed a refined algorithm that utilizes end-expiratory molar mass instead, resulting in more accurate LCI determination. In a study of flow dependence of specific airway resistance (sRaw) measurement using whole body plethysmography, Coutier et al. demonstrated that sRaw can be affected by the range of flows generated during the panting maneuver used to measure sRaw; narrowing this flow interval allowed better discrimination between asthma and normal children²⁴.

Low and middle income countries have a heavy burden of infant respiratory disease, but resources and environment in these countries limit the ability to use conventional techniques for sedated infant lung function testing. Gray et al. conducted a pilot study in a semi-rural area of South

Africa demonstrating the feasibility of obtaining tidal breathing recordings, exhaled nitric oxide, and multiple breath washout data in unsedated infants ²⁵. Obtaining data outside of the pulmonary function laboratory will allow for the collection of a larger and more diverse set of normal reference values, which increases the possibility of furthering our understanding of infant respiratory morbidity in third world countries.

Tidal breathing analysis is an especially appealing technique since it is non-invasive, does not require sedation and only minimal cooperation is needed to assess respiratory function ²⁶. In children following surgical repair of congenital diaphragmatic hernia, Laviola et al. used opto-electronic plethysmography to study thoraco-abdominal asynchrony and reported that diaphragmatic patching is associated with less asynchrony (or abnormality) compared to the primary suture approach to management ²⁷. Further study is required to determine if these findings are clinically relevant. Using respiratory inductance plethysmography (RIP) and measurement of the electrical activity of the diaphragm, Pham et al. demonstrated that high flow nasal cannula (HFNC) therapy in infants with bronchiolitis resulted in decreased work of breathing ²⁸. These findings support the use of HFNC in bronchiolitis, suggesting that RIP may provide an objective measure of the effect of HFNC on respiratory mechanics in this group of patients.

Preterm birth often leads to disrupted alveolar-capillary development ²⁹. Assaf et al. measured the diffusion capacity of the lung for carbon monoxide in healthy preterm (HP) infants and normal full term infants ¹⁴. Surprisingly, DLCO was actually higher in HP infants compared to normal controls, and not associated with gestational age or duration of mechanical ventilation after adjusting for body length, sex, and race. However, a higher DLCO was associated with an increased number of pro-angiogenic circulating hematopoietic stem/progenitor cells and treatment with CPAP; thereby, identifying potential novel approaches for treatment and monitoring of preterm lung disease. Although most preterm

infants receive respiratory support for only the first few weeks of life, some infants require long term mechanical ventilation, and little is known about their lung function.

Physiologic measurements also provide insight into the pathogenesis of different pediatric respiratory diseases. Mayer et al. prospectively performed modified spirometry in a cohort of patients with Duchenne muscular dystrophy and showed a rate of decline in forced vital capacity of approximately 5 %-predicted points per year between the ages of 5 to 24 years³⁰. These data will be helpful in calculating sample sizes for future interventional trials. In 5 to 7 year old children previously hospitalized for bronchiolitis as infants, Lauhkonen et al.³¹ performed impulse oscillometry and found that persistent severe deficits were present in only a small minority of study subjects, suggesting that permanent lung function reduction associated with infantile bronchiolitis occurs in later childhood.

Respiratory infection

Viral infections

Viral lower respiratory tract infection (LRTI) in young children continues to be of intense research interest, not least because since it may predispose to asthma and decrements in lung function in later life. Studies of risk factors for severe LRTI found that increased levels of maternal folate in mid pregnancy are associated with a decreased risk of LRTI by 6 months of age, and correlate with cord blood IL-10 levels and inversely with cord blood eosinophil counts³², while bronchiolitis cases with blood eosinophilia had an increased length of hospital stay (LOS) and were more often mechanically ventilated (24.2%) than those without eosinophilia (7.2%) or without blood counts (0.7%)³³. Geographic clustering of LRTI cases identified air pollution and poor housing as community level risk factors for wheezing LRTI and viral LRTI, respectively, with higher socio-economic status reducing the risk³⁴. Such community level risk factors may enable multifaceted interventions in communities to reduce childhood LRTI.

RSV immune prophylaxis efficacy was studied retrospectively in several populations. In children with CF, routine RSV-prophylaxis significantly reduces RSV hospitalizations but has no impact on lung function and growth at 6 years of age ³⁵. In children with congenital heart disease, RSV prophylaxis significantly reduces all LRTI, LRTI-hospitalizations, and intensive care admissions ³⁶, but it does not seem to have an effect on hospitalizations in children with idiopathic lung disease, who have more frequent and longer RSV-hospitalizations than healthy children ³⁷.

Current 'hot topics' in bronchiolitis management include hypertonic saline (HS) inhalation, non-invasive ventilation (NIV), and O₂-saturation targets. An RCT in 68 infants with hospitalized bronchiolitis compared 3%HS to normal saline inhalation, both given with salbutamol, and did not find any difference in LOS or severity scores, but more cough and rhinorrhea after HS ³⁸. These findings do not support routine HS use in bronchiolitis, in keeping with 2 recent larger RCTs ^{39,40} and a systematic review with meta-analysis ⁴¹. Noninvasive ventilation (NIV) is often used in acute bronchiolitis. Assessment of diaphragmatic electrical activity and esophageal pressure changes showed that high flow nasal cannula therapy offloads the diaphragm and reduces work of breathing in bronchiolitis ⁴². However, in a multicenter prospective audit NIV did not reduce the need for endotracheal intubation and ventilation in ex-premature infants (32-35 weeks of gestation) with bronchiolitis ⁴³, suggesting that further studies of NIV outcomes are required. Despite a recommended 90% O₂ saturation target for children with bronchiolitis (American Academy of Pediatrics), clinical practice varies considerably often targeting higher O₂ saturations. A recent multicenter equivalence RCT in acute bronchiolitis demonstrates that the 90% O₂-saturation target is safe and that it may reduce the time until infants requiring oxygen become fit for discharge ⁴⁴.

It remains important to better understand the risk factors for long term sequelae of early childhood LRTI. In indigenous Australian infants, persisting symptoms at 3 weeks after acute bronchiolitis are associated with an increased risk for subsequent bronchiectasis, and previous

hospitalization and household smoke are risk factors for respiratory readmissions ⁴⁵. Thus, optimized care following bronchiolitis and elimination of smoke exposure could improve long-term outcomes. The post-bronchiolitis risk of recurrent wheeze/asthma is modified by gender, with an increased risk in boys ⁴⁶, by excess weight at school age, but not by birth weight or excess weight in the first 1.5 years of life ⁴⁷, and by polymorphisms in the TLR4, CD14, and IL-13 genes ⁴⁸.

Community acquired pneumonia and parapneumonic effusion

While viral infection remains the most common cause of community acquired pneumonia (CAP) in U.S. children ⁴⁹, risk for bacterial infection and optimal use of antibiotics for severe CAP are still important issues worldwide. Second hand smoke (SHS) is a well-known risk factor. This was reinforced by a report from the Centers for Disease Control and Prevention's Etiology of Pneumonia in the Community study, in which children hospitalized with CAP from households with ≥ 2 smokers had a longer length of stay and were more likely to require intensive care compared with children from households with no smokers ⁵⁰.

Recommendations to use narrower spectrum antibiotics for CAP have resulted in declining use of cephalosporins in some areas ⁵¹. However, interesting data were reported by Breuer et al. ⁵² who carried out a retrospective study of 337 children hospitalized with community acquired pneumonia (CAP) and compared outcomes between children treated with narrow spectrum antibiotics (penicillin, ampicillin, and amoxicillin) vs. broad spectrum antibiotics (ceftriaxone, cefuroxime, cefazolin). Children treated more broadly had statistically shorter admissions and fever duration. In a randomized placebo controlled trial, administration of azithromycin early in the course of illness significantly reduced severity of subsequent lower respiratory tract illness, in preschool children with histories of recurrent illness ⁵³; whether this is related to antimicrobial or anti-inflammatory effects is unclear. The Tucson

Children's Study group reported evidence that early pneumonia may be among the most important early life risk factors for adult lung disease ⁵⁴.

Parapneumonic effusion (PPE) is an important and common complication of bacterial pneumonia, and its optimal management is still debated. Kontouli et al. ⁵⁵ reported on lung function and exercise capacity outcomes 2 years after PPE in a prospective study of 51 children, and found lower FVC % predicted, FEV1 % predicted, and FEV1/FVC in these children compared to healthy controls, but these changes were not felt to be clinically important. In another prospective study ⁵⁶, children < 16 years hospitalized with CAP were followed prospectively and 25% developed PPE. Not surprisingly, evidence of bacterial infection was associated with increased risk for PPE. Interestingly, ibuprofen use prior to admission was also associated with increased PPE risk. Finally, Hanson and colleagues ⁵⁷ carried out an elegant prospective crossover trial in which children with PPE (mean age 3.5 yr) referred to interventional radiology were randomized to one of two regimens involving fibrinolysis with alteplase 0.1 mg/kg twice a day alternating with normal saline twice a day. Effusion volumes were followed with low dose CT. Alteplase resulted in reduction in PPE volumes compared to normal saline; and earlier administration of alteplase (days 1 and 3) also performed better than later (days 2 and 4).

Conclusions

In the past year, many articles have been published in Pediatric Pulmonology and elsewhere, to further advance our understanding of neonatal lung disease, pediatric pulmonary physiology, and respiratory infection in children. Subsequent articles in this Year in Review series will cover sleep and breathing disorders, cystic fibrosis, asthma, infection, diagnostic testing, rare lung diseases, and neuromuscular disorders.

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